DMA-5016
Rev. 10/94

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE

_____ COUNTY DEPARTMENT OF SOCIAL SERVICES

NOTIFICATION OF ELIGIBILITY FOR MEDICAID/AMOUNT AND EFFECTIVE DATE OF PATIENT'S LIABILITY

FACILITY NAME: _____

ADDRESS: _____

_____

PATIENT'S NAME:_____**MID#:**_____
First **MI** **Last**

☐ **PML for MONTH(S) OF CHANGE—DATES:** _____ **AMOUNT:** _____

DATES: _____ **AMOUNT:** _____

☐ **PML until further notice—** **START DATE:** _____ **AMOUNT:** _____

Responsible Relative Name, Address, & Phone Number:

_____

_____

_____

Documentation required:
Original—Mail to facility
One copy—DSS file

Signature:_____
County Director of Social Services
Date:_____

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